AdventHealth

PATIENT PHOTOGRAPHIC AUTHORIZATION, RELEASE AND DISCHARGE
AdventHealth Medical Group Plastic & Reconstructive Surgery at Orlando

I consent to the taking of photographs, slides, audio/videotapes and other images ("imaging records") by Dr. Joseph Lopez or his designee of me or of my likeness or parts of my body in connection with the planned plastic surgery procedures(s) to be performed by Dr. Joseph Lopez and AdventHealth Medical Group Plastic & Reconstructive Surgery/ Head & Neck Surgery at Orlando.

I understand that my photographs, slides, imaging records, or illustrations may be used for academic or marketing purposes. Although every effort will be made to conceal my identity, given the nature of certain photography and/or medical conditions, it is possible that someone could recognize me. These purposes may include, but are not limited to academic publications, educational materials and textbooks, live or web-based medical lectures, presentations, teaching materials, website, print, online and social media. I understand that my likeness or photographs may become part of the public domain, shared, and viewed by a wide audience.

I grant permission for the use of my medical records including photographs, slides, imaging records, or illustrations in examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery.

I understand that I may revoke my consent at any time. However, it will not affect any information that was already disclosed. I waive all rights, interests, and claims for payment in connection with any use or disclosure of this information.

I release Dr. Joseph Lopez and the AdventHealth Hospital System, and their trustees, officers, agents and employees from all liability connected with the use or disclosure of this information. This consent is voluntary, and I give it in the interest of informing the medical profession and general public about plastic surgery methods, trends, advances and similar matters. This form will in no way affect my healthcare, payment for healthcare, and healthcare benefits.

PATIENT _____ *Date* _____

WITNESS/PHYSICIAN: _____ *Date* _____

I have read the above. I am the parent, guardian or conservator of a minor. I am authorized to sign this consent on his/her behalf, and I grant this consent as a voluntary contribution in the interest of public education.

Parent/Guardian _____ *Date* _____

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Patient Consent and Release for Medical Photography and Video

I, _____, do hereby voluntarily authorized by Dr. Joseph Lopez to take and use medical photographs or films of me, and/or interview me.

I authorize the use of my photos/films in the formats listed below. I waive any right to inspect or approve the finished product, advertising, or other copy that may be used in connection with the options below.

I understand that I will never be identified by name in any use of these photographs, but that in some circumstances the photographs may portray features which make my identity recognizable. I understand that photos may become part of the public domain, shared, and viewed by a wide audience.

(Please **initial** YES or NO for each of the items below.)

_____ YES _____ NO For our **office photo gallery** to help future patients understand and see outcomes from surgery/treatments with Dr. Joseph Lopez
_____ YES _____ NO On our **website or affiliated websites** for prospective patients to see and understand outcomes from surgery/treatments with Dr. Joseph Lopez
_____ YES _____ NO For **office patient education materials**
_____ YES _____ NO For **office marketing and advertising materials *including <u>social media</u>**
_____ YES _____ NO For **newspaper and magazine articles in** which my surgeon participates
_____ YES _____ NO For **lectures and multimedia presentations** given by my surgeon for educational purposes

I, on behalf of myself, or if the Subject is a minor, on behalf of my minor child, grant to AdventHealth on a perpetual, irrevocable and unrestricted basis the right to use, reuse, publish and re-publish photographic portraits or pictures and/or video tape footage of the Subject (the "Subject's Likeness"), in which the Subject's Likeness may be included as a composite or distorted in character or form, and whether in conjunction with the Subject's own name or a fictitious name. The right granted herein to use the Subject's Likeness shall extend to any reproductions in color or otherwise, made through any medium and in any and all media now or hereafter known whether employed singularly or in conjunction with printed and/or other accompanying material and whether employed for any purpose whatsoever, and regardless of the manner in which said use is transmitted.

The Subject waives any right to inspect or approve the finished product or products and/or the advertising copy or other matter containing the Subject's Likeness. The Subject further waives any right to compensation received by AdventHealth in association with the commercialization of the Subject's Likeness.

THE SUBJECT RELEASES AND AGREES TO HOLD HARMLESS ADVENTHEALTH, ITS EMPLOYEES, OFFICERS AND AGENTS, FROM ANY LIABILITY ASSOCIATED WITH THIS GRANT, INCLUDING WITHOUT LIMITATION ANY CLAIMS FOR LIBEL OR INVASION OF PRIVACY.

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For purposes of this grant, the term "AdventHealth" shall include all business entities, which are now or in the future owned or controlled or managed by AdventHealth.

I warrant that I am over the age of 18 and have the right to contract in my name, or on behalf of the Subject, if the Subject is a minor child. I have read and understand the content of this document prior to signing it. This release shall be binding upon the Subject, his heirs, legal representatives and assigns, and the individual (including the individual's heirs, legal representatives and assigns) executing this document in those circumstances where the Subject is a minor child.

The patient or the patient's representative must read and initial the following statements:

a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
Initials: _____

b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
Initials: _____

c. I understand that I may revoke this Authorization at any time by notifying the AdventHealth Entity in writing, but if I do, it will not have any effect on any actions the AdventHealth Entity took before it received the revocation.
Initials: _____

_____ _____
Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

Printed name of patient's representative: _____

Reason Authorization signed by patient's representative: (Check one)

_____ Minor

_____ Other (Explain):_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION